Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUGAR LAND SURGICAL HOSPITAL
1211 HIGHWAY 6 STE 70
SUGARLAND TX 77478

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-1915-01

MFDR Date Received
January 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Request for Reconsideration: "The enclosed claim was reimbursed incorrectly. Effective March 1, 2008 WC claims reimbursement is based on the Medicare Part a Reimbursement plus the percentage specified by the state. The payment noted above was I correct based on the new Hospital Workers Compensation Fee Schedule."

Amount in Dispute: $2,009.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Sugarland Surgical Hospital has been appropriately reimbursed for services rendered to [injured worker] for the 10/05/2010 date of service."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2010	Outpatient Hospital Services	$2,009.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 12, 2010 and December 30, 2010:

- 16, X936 – CPT or HPC is required to determine if services are payable.
- 150, X901 – Documentation does not support level of service billed.
- 150, Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
- 42, Z710 – This charge for this procedure exceeds the fee schedule allowance.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code: 150, X901, - Documentation does not support level of service billed. The operative report does not support the use of modifier -59 with CPT Code 29875; therefore the insurance carrier has supported their position.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,210.06. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $1,198.20. The non-labor related portion is 40% of the APC rate or $806.71. The sum of the labor and non-labor related amounts is $2,004.91. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $2,004.91. This amount multiplied by 200% yields a MAR of $4,009.82.

   - Procedure code 29875 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,210.06. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $1,198.20. The non-labor related portion is 40% of the APC rate or $806.71. The sum of the labor and non-labor related amounts is $2,004.91. The cost of this service does not exceed the

annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,002.46. This amount multiplied by 200% yields a MAR of $2,004.91. Review of the operative report reveals modifier -59 is not supported. CMS does not allow separate reporting of a procedure designated as a separate procedure when it is performed at the same patient encounter as another procedure in an anatomically related area through the same incision or surgical approach. Reimbursement is not recommended.

- Per CMS correct coding edits, procedure code 29877 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services §134.203. The fee listed for this code in the applicable Medicare fee schedule is $3.00. 125% of this amount is $3.75.
- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services §134.203. The fee listed for this code in the applicable Medicare fee schedule is $15.14. 125% of this amount is $18.93. The respondent made payment of $30.28 therefore, additional reimbursement is not recommended.

5. The total recommended payment for the services in dispute is $4,032.50. This amount less the amount previously paid by the insurance carrier of $4,037.78 leaves an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 9, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.